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AVITA HEALTH AND REHAB AT REEDS COVE	2114 N 127TH CT EAST WICHITA, KS 67228

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F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey, a non-compliance revisit, and complaint investigation #71552.	F 000		
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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F 156	Continued From page 2 The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: The facility had a census of 58 with 10 residents reported as attending the resident council meeting for 12/2013. Based on observation and interview the facility failed to review the residents facility rights during the resident council meeting. Findings included: - During an 1/22/14 at 1:30 PM resident #86 reported staff had not reviewed the resident's rights during the resident council meetings. During an interview on 1/22/14 at 9:24 administrative staff O reported he/she was unaware of the requirement to review the resident's rights. The facility failed to review residents rights during the resident council meetings.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an	F 157		

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accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
The facility census totaled 58 residents with 22 included in the sample. Based on observation, interview and record review, the facility failed to notify the physician of a severe weight loss for 1 of 4 residents reviewed for nutrition. (#18)

Findings included:

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F 157	Continued From page 4 - Resident #18 admitted to the facility on 11/1/13. Review of the resident's admission MDS (minimum data set) dated 11/7/13 revealed a BIMS (brief interview for mental status) score of 15, indicating no cognitive impairment. The resident required supervision and assistance of one staff for eating, and had total dependence on two or more staff for transfers and locomotion on and off the unit. The resident indicated it was somewhat important for him/her to have snacks available between meals. The resident did not have any oral/dental concerns or swallowing problems. The resident had not had any significant weight gain or loss. The resident did not have any nutritional approaches in place. Review of the Nutritional Status CAA (care area assessment) dated 11/12/13 revealed the area had triggered and the analysis of findings indicated the resident was not at risk for nutritional imbalance. Review of the ADL (activities of daily living) Functional/Rehabilitation CAA dated 11/11/13 revealed the resident needed total assistance with all ADLs of two or more staff and required transfers with a mechanical lift and assistance of two or more staff. The resident also needed cues and at times assistance with eating. The resident used a wheelchair and required one staff to propel his/her wheelchair. Review of the resident's care plan initiated 11/5/13, revealed a goal to maintain the resident's weight at 180 lbs. (pounds) plus or minus 5 lbs. (initiated 12/29/13) and a goal to maintain the resident's weight within 5 lbs of his/her baseline (initiated 1/8/14 and interventions directed staff to	F 157		

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weigh the resident weekly and report changes of plus or minus 3 lbs to the charge nurse (initiated 11/8/13, revised 12/29/13), add enhanced foods/proteins to a regular diet (added 12/3/13 revised 12/29/13), consult psychology for depression evaluation (11/20/13), manage medical problems effectively so as not to negatively impact the resident's appetite (revised 12/29/13), give the resident supplements as ordered and alert the nurse/dietician if the resident did not consuming regularly (initiated 1/8/14), monitor and record the resident's food intake at each meal (initiated 1/8/14), offer substitutes as requested or indicated (initiated 1/8/14), Add extra protein at meals and add enhanced foods to diet (initiated 11/5/13 and again on 1/8/14 as a duplicate).

Review of a physician's progress note dated 11/2/13 revealed the resident did not have edema.

Review of a physician order on 11/5/13 revealed an order for a regular diet with extra protein at meals and enhanced foods.

Review of the physician orders from 11/1/13 to 1/22/14 revealed no further physician orders related to dietary interventions, including supplements.

Review of the nurses notes from 11/1/13 to 1/22/14 revealed no evidence of physician notification of significant weight loss.

Review of all of the resident's weights revealed the following: on 11/1/13 weighed 204 lbs, on 11/25/13 weighed 182.6 lbs at 8:07 a.m. and weighed 184.8 lbs, on 12/02/13 weighed 183.8

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lbs, on 12/7/13 weighed 182 lbs, on 12/9/13 weighed 182 lbs, on 12/12/13 weighed 180.6 lbs, on 12/19/13 weighed 180.6 lbs, 12/31/13 weighed 179.6 lbs, on 1/1/14 weighed 176.4 lbs, on 1/4/14 weighed 178 lbs, on 1/8/14 weighed 177.6 lbs, on 1/15/13 weighed 175 lbs, and on 1/24/14 weighed 176 lbs.

Interview on 1/23/14 at 12:15 p.m. with physician staff X revealed the resident's weights had not flagged as being excessive. Staff X reported the resident had pain and nausea issues originally when he/she came in, but had been eating better as those things were controlled. Staff X reported the dietician alerted him/her of any residents flagged with any significant weight loss and then he/she decided what to add as far as interventions to prevent further weight loss. Staff X reported the resident had never flagged as a significant weight loss. Staff X reported he/she and the dietician communicated via text, e-mail, and verbally frequently about various issues in the facility, but the resident's weight loss had not been brought up as a concern. Staff X reported no one specifically said the resident had lost weight and it had not been brought to his/her attention. Staff X reported in general, 13.5% in two months was a significant weight loss, but for this resident, it was not an unhealthy thing for him/her to lose the weight. Staff X reported he/she did not recall having a conversation with staff or the resident about him/her wanting to lose weight.

Review of the undated facility Weight Policy revealed "Residents weighing +/- 3 pounds from previous weight will be reweighed. Significant weight loss or gain of 5% or greater in 30 days, 7.5% or greater in 90 days, and 10% or greater in

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F 157	Continued From page 7 180 days will be charted upon by dietary staff and nutrition interventions as needed. Physician and resident family will be notified of any significant weight changes." The facility failed to notify the physician of severe weight loss for a resident.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents. Each resident lived in 1 of 3 houses. Based on observation, interview, and record review, the facility failed ensure the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility were available for examination and readily accessible to residents without the residents having to ask to review them. This had the potential to affect all residents in the facility. Findings included: - Observation at 2:01 P.M. on 1/15/14 in	F 167		

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Saghbene House revealed no survey results available to view, and no indication of where the survey results were located. Observation in Reddy House and Berlin-Sandy House also revealed no survey results or notice of their availability.

At 2:03 P.M. on 1/15/14, licensed nursing staff S reported he/she did not think the facility had any survey results since there had not been a survey, but if there were some, the results would be up front and not in one of the resident houses.

At 2:08 P.M. on 1/15/14, administrative staff R reported the survey results were located up at the front desk, and did not have any copies of the results available in the resident houses. Observation at the front desk revealed a binder on the receptionist desk labeled, "survey results." Administrative staff R reported family, visitors and residents in the houses would not know the location of the survey results without having to ask to see them. Staff R reported he/she had discussed putting them in a different location, but had not done so yet.

Review of the facility's undated Right to View Survey Results and Advocacy Agencies policy revealed, "The most recent statement of deficiencies will be maintained in a clearly labeled book available at the entrance to the facility and/or assisted living center. Elders, families and the public will be able to access the book without the necessity of asking for assistance from a facility employee.

The facility failed to have survey results from State inspections available for examination and readily accessible to residents without residents

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F 167	Continued From page 9 having to ask to review them.	F 167		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents with 22 residents included in the sample. Of those, 4 residents were reviewed for choices. Based on observation, interview and record review, the facility failed to ensure the resident's right to choose wake-up schedules for 1 of 4 sampled residents. (#103) - Review of resident #103's annual MDS (minimum data set) dated 12/19/13 revealed a BIMS (brief interview for mental status) score of 15 (cognitively intact). The resident required extensive assist of two staff for bed mobility, transfers, eating, and extensive assistance of one staff for walking in room/corridor, dressing, toilet use, and personal hygiene. The MDS identified it somewhat important to choose his/her own bedtime. Review of the resident's self care deficit care plan dated 1/3/14, revealed it lacked information regarding what time the resident preferred to wake up.	F 242		

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Review of the admission resident preferences worksheet revealed the resident preferred to get up around 8 a.m. went to bed around 10 p.m. took nap after breakfast at 9:00 a.m. and also after lunch 12:30 p.m.

Interview with the resident on 1/16/14 at 9:47 a.m. revealed the staff woke him/her earlier in the mornings than he/she would like. The resident reported if he/she was scheduled for a shower that day, they would get him/her out of bed regardless of his/her desire to sleep in late. The resident stated he/she did not have a preference on shower times but did not like to get up early in the mornings. The resident stated he/she had complained to staff but the schedule had not changed.

Observation on 1/21/14 at 7:23 a.m. revealed the resident sat in his/her wheelchair at the dining table, dressed in day clothes, shirt, slacks, and shoes, sipping a cup of coffee, and periodically moving about the dining room independently.

Interview with the family on 1/21/14 at 1:31 a.m. revealed the resident usually did not like to get up early in the morning when he/she lived at home and usually got up around 8 a.m.. Family reported they were aware the staff were getting the resident up early for showers and for breakfast and stated he/she had voiced his/her concerns to the facility about the times but the schedule had not changed.

Observation on 1/22/14 at 7:13 a.m. revealed direct care staff I assisted the resident with a shower in his/her bathroom. At 7:18 a.m. staff I assisted the resident with his/her clothing and

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F 242	Continued From page 11 grooming. During the process, the resident stated he/she was not an "early bird" and would prefer a shower once a week. Staff I continued with grooming and at 7:33 a.m. took the resident to a dining table with two other residents. The resident stated, "I think I'll go back to bed now.", but remained at the dining table. Interview with direct care staff I on 1/22/14 at 8:41 a.m. revealed the resident was scheduled for three showers a week per the bathing schedule. Staff I reported he/she did not know who made the schedule or how they decided which residents got showers on the day or evening shift. Staff I reported the resident was "fussy" in the mornings about getting up early for his/her showers but he/she reported the resident felt much better after the shower. Staff I reported the resident sometimes requested to sleep an extra 30 minutes in the mornings. Interview with administrative nurse staff C on 1/23/14 at 8:40 a.m. revealed as far as choices the residents were allowed to choose their own routine and if the resident's needs change, the care should change with it. Review of the undated facility elder directed care plan policy revealed the care planning process for each elder will include the interdisciplinary team, family members agreed to by the elder and the elder. The group will develop a plan of services provided by staff based on preferences, choices and clinical needs of the elder. The facility failed to allow the resident to choose when to get up in the morning.	F 242		
F 272	483.20(b)(1) COMPREHENSIVE	F 272		

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F 272 SS=E	Continued From page 12 ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 58 residents with 20 reviewed for comprehensive assessments. Based on observation, interview, and record review, the facility failed to assess 4 residents reviewed comprehensively. (#159 and #51 for dental concerns not identified, #18 for nutrition triggers not identified, and #71 for necessity of medication use)

Findings included:

- Review of resident #18's signed physician orders dated 12/20/13 revealed the following diagnoses: post laminectomy (a surgery to fuse one or more vertebra) syndrome in the lumbar region (a syndrome after a laminectomy surgery characterized by persistent and residual back or leg pain) and esophageal reflux (backflow of stomach contents to the esophagus). The resident admitted to the facility on 11/1/13.

Review of the resident's admission MDS (minimum data set) dated 11/7/13 revealed a BIMS (brief interview for mental status) score of 15, indicating no cognitive impairment. The resident required supervision and assistance of one staff for eating, and had total dependence on two or more staff for transfers and locomotion on and off the unit. The resident indicated it was somewhat important for him/her to have snacks available between meals. The resident did not have any oral/dental concerns or swallowing problems. The resident had not had any significant weight gain or loss. The resident did

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not have any nutritional approaches in place.

Review of the ADL (activities of daily living) Functional/Rehabilitation CAA dated 11/11/13 revealed the resident needed total assistance with all ADLs of two or more staff and required transfers with a mechanical lift and assistance of two or more staff. The resident also needed cues and at times assistance with eating. The resident used a wheelchair and required one staff to propel his/her wheelchair.

Review of the Nutritional Status CAA (care area assessment) dated 11/12/13 revealed the area had triggered and the analysis of findings indicated only that the resident was not at risk for nutritional imbalance.

Review of a physician order on 11/5/13 revealed an order for a regular diet with extra protein at meals and enhanced foods.

Review of the resident's meal intake from 11/5/13-11/20/13 revealed 13 times the resident ate 76-100%, 11 meals ate 51-75%, 5 meals ate 26-50%, 5 meals ate 0-25%, refused 3 meals, and staff had not documented 10 meals.

Review of all of the resident's weights revealed the following: on 11/1/13 weighed 204 lbs, on 11/25/13 weighed 182.6 lbs at 8:07 a.m. and weighed 184.8 lbs, on 12/02/13 weighed 183.8 lbs, on 12/7/13 weighed 182 lbs, on 12/9/13 weighed 182 lbs, on 12/12/13 weighed 180.6 lbs, on 12/19/13 weighed 180.6 lbs, 12/31/13 weighed 179.6 lbs, on 1/1/14 weighed 176.4 lbs, on 1/4/14 weighed 178 lbs, on 1/8/14 weighed 177.6 lbs, on 1/15/13 weighed 175 lbs, and on 1/24/14 weighed 176 lbs.

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Review of a Nutritional Risk Review dated 11/4/13 revealed the dietician recommended a regular diet with added protein at meals and to follow weekly weights and food intake. The resident's current body weight was 204 lbs and his/her ideal body weight was 185 lbs. No further nutritional risk review assessments were completed.

Review of a nurses note dated 11/15/13 revealed the resident admitted for skilled services with a diagnosis of status post lumbar fusion and required set up assistance of one person for meals and had improved po (by mouth) intake.

Review of a list of residents receiving fortified foods provided by the facility on 1/22/14 revealed the resident's name on the list.

Observation on 1/21/14 at 7:59 a.m. revealed the resident sat at the dining table and had a cup of coffee, and small glass of milk. At 8:27 a.m. the resident received a biscuit with sausage gravy. The resident drank all of his/her fluids and ate 1/2 of the biscuit with gravy.

Observation on 1/22/14 at 8:37 a.m. revealed the resident sat at the dining table and received a piece of wheat toast, 4 pieces of bacon, a cup of coffee and a large glass of water. The resident ate 1/2 a piece of toast, a piece of bacon, and drank all of his/her fluids. No staff were observed to offer the resident alternative foods or encourage the resident to eat.

Interview with the resident on 1/22/14 at 4:08 p.m. revealed he/she felt like he/she needed to lose the weight and he/she had been up over 200 lbs.

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The resident reported he/she was not concerned about the weight loss at all and felt like he/she had a good appetite.

Interview with direct care staff T on 1/21/13 at 3:51 p.m. revealed the resident required limited assistance getting to the dining room, set up assistance with eating, and the resident's appetite varied depending on the day.

Interview with licensed nursing staff V on 1/21/14 at 4:12 p.m. revealed the resident had lost weight and had a poor appetite at times, but it had improved.

Interview with licensed nursing staff G on 1/22/14 at 2:53 p.m. confirmed he/she developed comprehensive care plans with admission MDS assessments between 14 and 21 days of the resident admitting to the facility. Staff G reported the care plan was individualized based on the resident's needs based off of the CAA triggers, but even if an area did not trigger and he/she saw a need in an area, he/she went ahead and care plan for that problem. When a CAA triggered, staff G reported he/she tried to find out what made the area trigger and looked to find out if the trigger was appropriate by nurse interviews and nurses notes. Staff G reported the purpose of the CAA was to help staff develop a good plan of care and have good input for the resident.

Interview with administrative nursing staff B on 1/23/14 at 8:04 a.m. revealed he/she expected the comprehensive care plan to be developed within 7 days after the completion of the CAAs, and the purpose of the CAA was to take the information from the MDS to help form a personal, complete, comprehensive care plan.

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Staff B reported the CAAs showed where the information came from on the MDS to help with the critical thinking process and was a focused care area assessment from the data put into the MDS.

Interview on 1/23/14 at 12:15 p.m. with physician staff X reported the resident had pain and nausea issues originally when he/she came in, but had been eating better as those things were controlled.

Review of the undated facility policy for Comprehensive Assessment revealed, "The MDS will trigger any and all elements that need to be addressed in the elder's plan of care. These elements are known as the Care Area Assessment Summary (CAAs). Each CAA area triggered is noted on the MDS Resident Assessment Protocol Summary and requirements further assessed... After appropriate documentation on the MDS CAA Summaries, the RN [registered nurse] Assessment Coordinator must date and sign to verify that all triggered CAAs have been applied."

The facility failed to comprehensively assess and work through the triggered Nutritional CAA for a resident with factors influencing his/her nutritional status.

- Review of resident #71's signed physician orders dated 12/20/13 revealed the following diagnoses: acute but ill-defined cerebrovascular disease (poor blood flow to areas of the brain), low blood pressure, and essential hypertension (elevated blood pressure). The resident admitted on 10/10/13.

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Review of the admission MDS (minimum data set) dated 10/17/13 revealed a BIMS (brief interview for mental status) score of 12, indicating moderate cognitive impairment. The resident had a total mood severity score of 07, indicating mild depression. The resident did not have behaviors. During the 7 day lookback period, the resident received an antidepressant medication 7 days, a hypnotic medication 5 days, and an antibiotic medication 3 days.

Review of the quarterly MDS dated 1/4/14 revealed a BIMS score of 12, indicating moderate cognitive impairment. The resident had a total mood severity score of 07, indicating mild depression. The resident did not have behaviors. During the 7 day lookback period, the resident received antidepressant and antibiotic medications 7 days and a hypnotic medication 1 day.

Review of the Psychotropic Drug Use CAA (care area assessment) dated 10/22/13 revealed the following analysis of findings: "[Name] receives Citalopram Hydrobromide [an antidepressant medication] for depression, Ambien [a hypnotic medication] for sleep deprivation."

Review of the Cognitive Loss/Dementia CAA dated 10/22/13 revealed the following analysis of findings: "[Name] scored 12 of 15 on the BIMS, diagnosis of Ill defined cerebrovascular disease, ataxia [a neurological sign consisting of lack of voluntary coordination of muscle movements] as late effect of CVA [stroke-the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain], other late effects

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of CVA."
Interview with the resident on 1/21/14 at 10:35 a.m. confirmed the facility provided the resident's medications and he/she felt she got all of the medications he/she needed. The resident stated, "I sure do take a lot of pills, but I suppose they know what they are doing."

Interview with licensed nursing staff G on 1/22/14 at 2:53 p.m. confirmed he/she developed comprehensive care plans with admission MDS assessments between 14 and 21 days of the resident admitting to the facility. Staff G reported the care plan was individualized based on the resident's needs based off of the CAA triggers, but even if an area did not trigger and he/she saw a need in an area, he/she went ahead and care plan for that problem. When a CAA triggered, staff G reported he/she tried to find out what made the area trigger and looked to find out if the trigger was appropriate by nurse interviews and nurses notes. Staff G reported the purpose of the CAA was to help staff develop a good plan of care and have good input for the resident.

Interview with administrative nursing staff B on 1/23/14 at 8:04 a.m. revealed he/she expected the comprehensive care plan to be developed within 7 days after the completion of the CAAs, and the purpose of the CAA was to take the information from the MDS to help form a personal, complete, comprehensive care plan. Staff B reported the CAAs showed where the information came from on the MDS to help with the critical thinking process and was a focused care area assessment from the data put into the MDS.

Review of the undated facility policy for

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Comprehensive Assessment revealed, "The MDS will trigger any and all elements that need to be addressed in the elder's plan of care. These elements are known as the Care Area Assessment Summary (CAAs). Each CAA area triggered is noted on the MDS Resident Assessment Protocol Summary and requirements further assessed... After appropriate documentation on the MDS CAA Summaries, the RN [registered nurse] Assessment Coordinator must date and sign to verify that all triggered CAAs have been applied."

The facility failed to comprehensively assess and work through the triggered Psychotropic Drug Use and Cognitive Loss/Dementia CAAs for a resident with factors influencing the medications he/she received.

- Review of resident #159's admission MDS (minimum data set) dated 11/13/13 revealed a BIMS (brief interview for mental status) score of 15 (cognitively intact). The resident required extensive assistance of one staff for personal hygiene, and extensive of two staff for ADLs (activities of daily living). The MDS indicated the resident had no dental problems. The resident admitted on 11/7/13.

Review of the CAA (care area assessment) summary revealed the dental CAA did not trigger for further assessment/care plan.

Review of the resident's care plan for ADLs dated 11/25/13, revealed the resident required setup assistance with oral care in the morning and after meals, and required assistance of one staff for meal setup. The care plan lacked identification of any dental issues or missing teeth.

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Review of the medical record revealed the admission nurse assessment failed to identify any dental issues or missing teeth.

Review of the medical record from 11/7/13 to 1/23/13 revealed it lacked an admission dietary assessment.

Observation on 1/15/14 at 4:43 p.m. (during an interview) revealed the resident had a missing tooth on the bottom right side which was visible when the resident spoke or smiled. The resident stated at that time he/she had five missing teeth total.

An interview with direct care staff I on 1/22/14 at 8:41 a.m. revealed if a resident had missing teeth he/she told the nurse. Staff I reported he/she did not know the resident had missing teeth.

An interview with licensed nurse J on 1/22/14 at 8:56 a.m. revealed the admitting licensed nurse did a head-to-toe assessment which included specific questions for oral care. Staff J reported when direct care staff brought dental supplies such as toothpaste, toothbrushes, or denture cleaner, they also had opportunity for observation and reported to the nurse any concerns. Staff J reported no dental concerns were identified for this resident.

An interview with social services staff H on 1/22/14 at 9:31 a.m. revealed the nurse or the MDS coordinator informed him/her of any dental concerns for residents. Staff H then followed up and assisted with the appointment as well as transportation needs.

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An interview with administrative nurse G on 1/22/14 at 9:48 a.m. revealed, staff obtained the information regarding dental or oral status used for the MDS assessments primarily from the nurse's admission assessment. Staff G stated he/she did a second assessment to confirm the information was accurate and reported he/she had not identified missing teeth for this resident.

An interview on 1/22/14 at 3:31 p.m. revealed the resident reported he/she had missing teeth long before admission to the facility, but had no time to get to his/her own dentist. The resident reported the facility had never addressed the issue or asked about his/her teeth. The resident stated his/her front tooth was newly broken and he/she missed it stating, "It looked good when it was in." Observation at that time revealed the resident now had two visible teeth missing with the top front tooth included. The resident reported he/she did not know the facility could assist with dental appointments as well as transportation, and reported he/she would have gone to his/her own dentist if the facility had set up the appointment and provided transportation.

Review of the facility oral health care policy dated 12/4/13 revealed each elder will receive an oral assessment by a licensed nurse on admission. The assessment included the condition of the oral cavity, teeth, and tooth supporting structures, the presence or absence of natural teeth or dentures and the ability to function with or without natural teeth or dentures. The elder retains the right to go to a dentist of his/her choice and the facility will arrange transportation for elders if dental services are provided outside the facility.

The facility failed to comprehensively assess a

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resident's dental status.

- Review of resident #51's Admission MDS (minimum data set) dated 1/2/14 revealed a BIMS (brief interview for mental status) score of 10 (moderate cognitive impairment). The resident had no overall presence of behaviors and no rejection of care behaviors exhibited. It also identified the resident needed supervision with set up help for eating, and needed extensive assistance of 2 people for personal hygiene and bed mobility. The resident had no obvious cavity or broken natural teeth. The resident admitted on 12/27/13.

The Dental CAA (Care Area Assessment) did not trigger for this resident for the 1/2/14 MDS assessment.

Review of documentation in the resident's chart from 12/27/13-1/22/14, including physician orders, progress notes, and assessments revealed no information regarding the resident's chipped front tooth.

Review of the Admission Assessment dated 12/27/13 revealed the resident had no problems with her dental status and "broken, missing teeth" remained unmarked on the assessment.

On 1/22/14 at 10:00 a.m., observation revealed the resident's left front tooth was chipped, with about half of the tooth missing.

On 1/21/14 at 2:28 p.m., an interview with the resident revealed the chipped left front tooth did not bother him/her. He/She stated he/she did not really want to get it fixed since it did not cause

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any problems. The resident also stated he/she had chipped the tooth in a fall he/she had prior to admission to the facility.

On 1/21/14 at 3:36 p.m., an interview with licensed nursing staff F revealed MDS staff completed an oral assessment upon admission. Staff F stated the aides providing oral care were expected to let the nursing staff know if they identified a problem with the resident's teeth. Staff F also stated the resident had a chipped left front tooth and had it as long as he/she's known the resident. Staff F reported the resident had not mentioned anything about the chipped tooth or that he/she wanted the tooth fixed. Staff F stated the admission assessment addressed broken or missing teeth and confirmed the resident's admission assessment did not have any documentation of the chipped tooth and should have.

On 1/22/14 at 9:27 a.m., an interview with administrative nursing staff G revealed if a resident had oral pain, broken teeth, loose teeth, or dentures, staff documented the information in the oral section of the MDS. Staff G reported he/she used the admission assessment information as well as a visual assessment of the resident's mouth to guide how to code the oral section. Staff G confirmed the resident's MDS did not identify any missing or broken/chipped teeth.

On 1/22/14 at 2:42 p.m., an interview with administrative nursing staff B revealed staff were expected to perform a visual assessment of the resident's mouth in order to have the correct information for the MDS assessment and if staff found missing, loose, chipped, broken teeth, or non-fitting dentures, staff were expected to

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F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		

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due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility had a census of 58 with 16 sampled residents. Based on observation, record review, and interview, the facility failed to develop comprehensive cares plan for 3 of 16 residents. (#92, 172, 81)

Findings included:

- Review of resident #92's admission MDS (minimum data set) dated 11/7/13 revealed a BIMS (brief interview for mental status) score of 14 (cognitively intact). The resident required extensive assistance of one staff for bed mobility, transfers, with limited assistance for personal hygiene, and supervision for eating. The resident received dialysis (process where the blood is filtered and cleaned) and reported no pain. The resident admitted to the facility on 11/1/13.

Review of the resident's care plan for hemodialysis, initiated 11-1-13, revealed the resident received hemodialysis related to renal failure (kidney failure) and directed staff to apply lidocaine cream (a cream to numb the skin) to dialysis site before dialysis, not to draw lab or perform blood pressure in the arm with the dialysis shunt (a device implanted under the skin for access during dialysis treatment), and encourage the resident to go to dialysis appointments. The care plan lacked information which regarded monitoring of the dialysis shunt, monitoring of the blood pressures before and

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after treatment, weight monitoring, specific diet and/or fluid restrictions, and directions for staff communication with the dialysis facility regarding the resident's care.

Review of a dialysis communication tool (a form used to communicate with the dialysis facility) dated 12/31/13 revealed facility staff filled out the top portion regarding the resident's status prior to the dialysis treatment and the local dialysis facility staff completed the form with information for the facility regarding the treatment and any pertinent information needed for care of the resident. Review of the medical record lacked any other communication forms for any other dialysis treatments.

Observation on 1/22/14 at 11:19 a.m. revealed the resident left for dialysis with family and a sack lunch.

Review of the facility hemo dialysis policy dated 12/4/13 revealed the resident's overall comprehensive plan of care should include: times of dialysis therapy and dialysis access orders, dialysis clinic appointment and laboratory schedule, transportation arrangements, coordination between facility and involved certified dialysis center, address risk factors, potential complications and dialysis-related care needs identified in assessment process, special nutritional and fluid volume needs, risk for adverse medication effects, care of access site, infection control measures, monitoring of vital signs, weights and other monitoring requirements before and after dialysis treatments, and instructions for giving medications.

The facility failed to develop a comprehensive

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care plan to include all aspects of care for a resident receiving dialysis.

- Review of resident #172's admission MDS (minimum data set) dated 12/24/13 revealed a BIMS (brief interview for mental status) score of 15, indicating no cognitive impairment. The resident had no behaviors and had a mood severity score of 00, indicating no depression. The resident was considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have intellectual disability. The resident required extensive assistance of one staff for bed mobility, transfers, locomotion on the unit, dressing, toileting, and personal hygiene. The resident required limited assistance of one staff for walking in the room. The resident had an indwelling foley catheter and used a walker and wheelchair. The resident admitted on 12/19/13.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA dated 12/20/13 revealed the resident needed extensive assistance of one staff with ADLs. The resident needed assistance with bathing, toileting, grooming, and hand washing. The resident was continent of bowel, had a foley catheter to dependent drainage, and staff performed perineal care after each toilet use. The resident used a walker and wheelchair for mobility and required extensive assistance of one staff to propel his/her wheelchair.

Review of the CAA Summary dated 12/30/13 revealed the following areas triggered: ADL Functional/Rehabilitation Potential, Urinary Incontinence/Indwelling Catheter, Falls, Communication, and Pressure Ulcers. All areas

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were marked as care plan decisions as yes, except for Communication.

Review of the resident ' s care plan on 1/22/14 (day 34 from admission), initiated 12/26/13, revealed it lacked interventions directing staff as to the amount of assistance the resident required for any of the areas that triggered from the MDS.

Observation on 1/21/14 at 12:11 p.m. revealed the resident sat at a dining table and had a visitor with him/her. The resident had a crutch for his/her left side and a built-up shoe on the right foot. The resident had a foley catheter in a dignity bag that hung under the chair.

Observation on 1/22/14 at 8:50 a.m. revealed direct care staff K used a gait belt and walked with the resident to his/her room from the dining room.

Interview with direct care staff K on 1/22/14 at 8:44 a.m. revealed the resident required staff assistance with walking, toileting, transferring, and dressing.

Interview with direct care staff I on 1/22/14 at 9:41 a.m. revealed staff assisted the resident with walking, transferring with a gait belt, and emptying his/her foley catheter. Staff I reported if he/she had a question about the resident's care, he/she looked at the care plan first then asked the nurse.

Interview with licensed nursing staff EE on 1/22/14 at 11:49 a.m. revealed the resident required assistance of one staff for most cares and used a cane. Staff EE reported he/she expected the care plan to include the resident's

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problems, goals, and interventions to meet the goals. Staff EE reported he/she expected the resident's catheter and care to be on the care plan.

Interview with licensed nursing staff G on 1/22/14 at 2:53 p.m. confirmed he/she developed the resident's comprehensive care plan after the MDS admission assessment and it should be developed between 14 and 21 days of the resident's admission. Staff G reported he/she individualized each resident's care plan based on the resident's needs from the CAA triggers. Observation at that time revealed staff G looked at the resident's care plan and reported it was not comprehensive yet. Staff G reported he/she updated the resident's temporary care plan until he/she could complete a comprehensive care plan.

Interview with administrative nursing staff B on 1/23/14 at 8:04 a.m. revealed he/she expected the comprehensive care plan to be developed within 7 days after the completion of the CAAs.

Review of the undated facility policy for Elder Directed Care Plans revealed, "Within seven (7) days of completion of the comprehensive assessment, the Interdisciplinary team will develop a comprehensive care plan for each elder that includes measurable objectives and timetables to meet each elder's clinical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan will include: The services that are to be furnished to attain or maintain the elder's highest practicable physical, mental, and psychosocial well-being."

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The facility failed to develop the resident's comprehensive care plan in a timely manner to communicate to staff the assistance and services the resident required.

- Review of resident #81's signed physician orders dated 10/11/13 revealed the resident had a diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion) and admitted on 7/24/13.

Review of the resident's Significant Change MDS (minimum data set) dated 10/18/13 revealed the resident had long and short term memory problems and had a total mood severity score of 17, indicating moderately severe depression. The resident displayed physical behaviors toward others 4-6 days of the look back period, and displayed verbal behaviors toward others 1-3 days of the look back period. The resident did not display any rejection of care or wandering behaviors. It identified the resident did not have pain and did not receive any pain medication. It also identified the resident received an anti-psychotic medication 5-7 days of the look back period.

Review of the Behavioral Symptoms CAA (care area assessment) dated 10/18/13 revealed nursing staff reported the resident yelled out, scratched, attempted to bite, pinched, and hit.

Review of the Psychotropic Drug Use CAA dated 10/18/13 revealed the resident received Haldol (an anti-psychotic medication) for agitation, Mirtazapine (an anti-depressant medication) used for appetite stimulant, Seroquel (an anti-psychotic medication) for behaviors or aggression, and Lorazepam (an anti-anxiety medication) as

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needed for anxiety.

Review of the comprehensive care plan with a date of 7/25/13 revealed the resident used psychotropic drug therapy with Haldol and Geodon related to dementia behavioral issues. It directed staff to monitor for interactions/adverse consequences, document and record behaviors as they occurred. The care plan lacked any information identifying specific behaviors the resident displayed and lacked any interventions used to attempt to reduce behaviors.

On 1/21/14 at 3:23 p.m., an interview with direct care staff DD revealed the resident had behaviors but redirecting helped calm him/her down. Staff DD reported some of the behaviors included verbal behaviors but not so much physical behaviors. Staff DD also stated the behaviors were most likely from the resident's dementia.

On 1/22/14 at 12:52 p.m., an interview with administrative nursing staff J revealed the resident hit at staff, yelled out, and cursed.

On 1/23/14 at 7:35 a.m., an interview with administrative nursing staff B revealed if a resident had behaviors, staff were expected to put that information on the resident's care plan to identify the specific behaviors for that resident. Staff B also stated he/she expected interventions (non-pharmacological included) to be listed on the care plan.

Review of the undated facility policy for "Elder Directed Care Plans" revealed the following: "It is the policy of this facility to provide an individualized, interdisciplinary plan of care for all elders that is appropriate to the elder's needs,

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F 279	Continued From page 33 strengths, limitations and goals based on initial, recurrent and continual needs of the elder. Care, treatment, and services are planned and provided to each elder in an interdisciplinary, comprehensive and collaborative manner to ensure that all interventions are appropriate to needs of the elder. ...Care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals of the elder that are reasonable and measurable. The plan of care will be documented through the use of computerized care planning." The facility failed to develop a comprehensive care plan to include specific behaviors and interventions to manage them.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents with 22 residents included in the sample. Of those, 1 resident was reviewed for the coordination of care with hospice services. Based on observation, interview, and record review, the facility failed to maintain the resident's highest practicable	F 309		

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physical well-being in accordance with the comprehensive assessment and plan of care by the failure to coordinate a bathing schedule with hospice services for 1 of 1 sampled residents. (#39)

Findings included:

- Review of resident #39's Significant Change MDS (minimum data set) dated 12/3/13 revealed a BIMS (brief interview for mental status) score of 15 (cognitively intact). The resident needed extensive assistance of one person for personal hygiene and required total dependence of staff for bathing. It also identified the resident did not receive hospice or respite care.

Review of the ADL (activities of daily living) Functional/Rehabilitation Potential CAA (care area assessment) dated 12/3/13 revealed the resident had a diagnosis of kidney mesothelioma (a type of cancer), and had been doing chemotherapy for a while now. The resident had reported increased pain and felt his/her cancer aggressively progressing. The resident decided he/she wanted to be comfortable and no longer wanted chemotherapy. The CAA also revealed the resident needed extensive assistance of 2 people with ADLs and needed assistance with bathing, toileting, grooming, and hand washing.

Review of the care plan with a revision date of 12/16/13 revealed the resident had a "hospice" care plan from a local hospice care provider. The care plan identified the resident was a DNR (do not resuscitate). The facility care plan revealed the hospice care provider planned to provide the resident 2 showers/baths a week.

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Review of the facility Admission Assessment dated 10/15/13 revealed no information regarding how often the resident preferred to bathe each week.

On 1/21/14 at 8:02 a.m., observation revealed the resident asked the staff member to assist with oral care. Direct care staff D assisted the resident back to his/her room and reported he/she would help the resident.

During an interview on 1/21/14 at 3:00 p.m., direct care staff Y reported staff assisted the resident with all morning cares and administered medications to the resident. Staff Y reported he/she thought hospice staff assisted the resident with all baths.

On 1/21/14 at 3:05 p.m., direct care staff D reported he/she often worked with the resident and reported the resident received two baths a week from hospice services, then facility staff provided the resident with a bath each Saturday.

At 3:50 p.m. on 1/21/14 licensed nursing staff F reported hospice staff provided the resident with baths 2 times a week and the facility provided one bath a week.

On 1/22/14 at 8:24 a.m. direct care staff E reported the facility gave 3 showers a week to all residents unless a resident wanted more than that. For resident #39, hospice provided the resident 2 showers a week and facility staff helped the resident with the third shower on Saturdays. Staff E reported the resident had never asked for any more than 3 showers a week.

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F 309	Continued From page 36 On 1/22/14 at 11:17 a.m., the resident reported he/she received a bath 3 times a week, hospice staff provided 2 baths, and the facility provided a third bath on the weekend. The resident reported he/she wanted more than just the 3 baths each week. On 1/22/14 at 2:47 p.m. administrative nursing staff B reported the facility and hospice services decided mutually who provided which cares for the resident. Staff B reported the facility had a standard of providing 3 baths per week, but a resident could have more if they wanted, and reported he/she expected the facility's staff to continue providing all normal/daily cares for the resident, and then hospice staff provided services in addition to the facility's normal routine. Review of the bathing record from 1/7/14 to 1/22/14 revealed the resident received a bath on 1/7, 1/9, 1/12, 1/14, 1/16, 1/18, and 1/21/14 (approximately 3 times each week). Review of the undated facility policy for Bath and Shower revealed, "It is the policy of the Facility to ensure the residents' baths and showers are performed and documented as scheduled, to maintain each resident's hygiene and dignity." The facility failed to ensure the coordination of care with hospice services in order for the resident to receive the 3 baths provided weekly by the facility, and the 2 baths provided weekly, in addition, by hospice services.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

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environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 58 with 22 sampled residents. Based on observation, record review, and interview the facility failed to provide sufficient supervision for fall prevention which affected 1 of 3 residents reviewed. (#103) The facility also failed to secure chemicals and medications in an area inaccessible to residents and maintain safe water temperatures in public area of resident use. These failures had the potential to affect 2 cognitively impaired and independently mobile residents and the 56 residents able to access water in public use area, as reported by the facility.

Findings included:

- Review of resident # 103's annual MDS (minimum data set) dated 12/19/13 revealed a BIMS (brief interview for mental status) score of 15, indicating no cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfers, eating, and extensive assistance of one staff for walking in room/corridor, dressing, toilet use, and personal hygiene. The resident had two or more falls since admission or the prior assessment.

Review of the falls CAA (care area assessment) dated 12/19/13 revealed an objective which

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ensured the resident's safety and minimized potential for injury as well as minimized his/her potential for falls. The resident had decreased safety awareness, weakness, and required the extensive assistance of one person for ADLs (activities of daily living) with multiple falls in the past. He/she had an unsteady gait and balance problems, yet attempted ambulation independently. On 12/14/13 the resident had a fall risk assessment score of 15 which indicated high fall risk.

Review of the resident's current care plan for falls revealed the resident was at risk for falls due to a history of 3 falls in the past three months, confusion, attempting to pick things up off the floor and had fallen forward, impaired balance, poor safety awareness, and required assistance of one staff for walking, dressing, toileting, personal hygiene, and bathing and two staff for bed mobility and transfers. The care plan directed staff to have non-skid surface to wheelchair, remind the resident to have a reacher (an extended reach grabbing device) with him/her at all times, (revised on 12/29/14) for neurological checks with all falls, pendant call light given, clip the room call light at the top of the left assistive bar on his/her bed rail, serve breakfast after most residents to prevent leaving the table after meals, toilet after eating, remind to use call light, when anxious place in dining area, provide diversional activity, cards, dominoes, or puzzles, bed alarm to bed, when eating push to the table as several falls were from trying to pick up things off the floor, when not in bed encourage the resident to sit in the dining area or community tv area, and provide activity as available.

Review of the fall risk assessment dated 12/24/13

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revealed a score of 15, which indicated high fall risk.

Review of the fall investigation dated 12/21/13 at 3:45 p.m. revealed staff found the resident lying down face up on the ground. Staff noted no injury except for skin tears to the right arm. Staff took vital signs and were within normal limits, completed an assessment, and completed neurological checks. The resident had eaten in the dining room and staff found him/her on the floor by the dining room. The interventions in place were feed the resident after other residents, encourage the resident to stay around the dining area or in an activity, and evaluate for possible reacher use.

Review of a rehabilitation screening note on 12/23/13 revealed the resident had a recent fall while he/she reached for things on the floor, so staff gave the resident a reacher. The resident continued to require minimal assistance for transfers.

Observation on 1/21/13 at 8:08 a.m. revealed the resident sat in his/her wheelchair in the dining area, he/she reached down to pick up a piece of trash off the floor. Two staff sat at a table across the dining room, one with his/her back to the dining area, the other sat with his/her head down and worked on paper work. No other direct care staff were present in the dining area. The resident did not have a reacher or call pendent on his/her person.

Observation on 1/21/14 at 8:50 a.m. revealed the resident sat in his/her wheelchair at the dining table dressed in a dark blue shirt, tan slacks, velcro non-skid shoes, had a non-skid device

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under the cushion in his wheelchair seat, and did not have the call pendent on or a reacher device. The resident ate a bowl of hot cereal which had mostly milk in the bowl. Another resident who sat at the same table, asked for the resident to be pushed up closer to the table as he/she was spilling milk on his/her shirt protector. Direct care staff I pushed the resident's wheelchair closer to the table and explained the resident moved around a lot and that was why he/she was so far back from the table. Observation revealed the resident moved several times from his/her table to the kitchen counter to get items or ask the staff for things.

Observation on 1/21/14 at 9:19 a.m. revealed the resident finished breakfast and left the dining table. He/she headed for the door to the hallway, when licensed nurse staff L approached the resident and asked if he/she needed help. The resident stated he/she was going to therapy. Staff L told the resident that therapy would come for him/her when it was time. The resident turned around and self-propelled around the nurse station, then to his/her room, staff did not redirect him/her or attempt to engage the resident in an activity. The resident did not have a reacher or call pendent on his/her person.

Observation on 1/21/14 at 9:34 - 9:55 a.m. revealed the resident sat in his/her room. The resident reported he/she was concerned about a pair of nail clippers on his/her room floor, stating "I don't know how they could have gotten there, they need to be picked up." The resident stated he/she had been given a reacher for his/her birthday but rarely used it to pick up things even though he/she had fallen several times from reaching down. The resident located the reacher

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beside his/her dresser, and stated staff did not encourage him/her to use it, and it was up to him/her to decide to use it. The resident also located two call light pendents hanging on the oxygen meter on the wall, and reported he/she wore them if he/she remembered. The resident stated staff told him/her to go to his/her room after breakfast and staff would assist him/her to lay in bed. At 10:09 a.m., the resident transferred him/herself from the wheelchair to the bed, laid on the bed with his/her feet hanging off the side and began yelling for help. Direct care staff I entered the room at 10:14 a.m., addressed the resident, asked if he/she needed anything, spoke to the resident for a few minutes and left the room.

Observation on 1/22/14 at 7:29 a.m. revealed direct care staff I transferred the resident from a shower chair to his/her wheelchair. Staff I provided moderate assistance for the transfer from the shower. Staff I reported the resident received therapy and improved with transfers. Observation revealed the resident had shaky legs and could not pick his/her feet up enough to make a 90 degree turn from one chair to another. Staff I directed the resident's body to the wheelchair.

Observation on 1/22/14 at 8:20 a.m. resident sat at the dining table, dropped a piece of bacon on the floor, scooted his/her wheelchair back, and attempted to pick it up off the floor. Direct care staff I was assisting another resident when he/she noticed the resident attempting to pick the bacon off the floor. Staff I approached the resident and told him/her to leave it that the housekeeping staff would vacuum after breakfast. The resident insisted on picking it up,

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while he/she continued to reach for the bacon and stated "I can't just leave it." Staff I could not dissuade the resident so he/she picked up the bacon put it in the trash. The resident did not have a reacher or call pendent on his/her person.

Interview with family on 1/21/14 at 1:31 p.m. revealed the resident had several falls, had a significant mental status change after the last surgery back in November 2013, and had never seemed to recover. Family stated the resident was hard headed, and refused to use the adaptive aid (reacher) given to him/her by the family. Family stated the resident did not think he/she needed to use it. Family also stated the resident did not want to wear the call pendent as requested and did not remember to put it on. Family did not know if staff encouraged the use or not. Family stated the staff tried very hard to supervise the resident and could only do so much. Family agreed there was a lack of supervision and the resident had required more supervision over time. Family stated the resident received therapy to try and strengthen his/her legs so he/she could do more walking and stated staff did not have the time to walk him/her even to the bathroom. Family reported the resident had become weaker, and feared the resident would have more falls in the future due to the weakness and lack of supervision. Family stated he/she had reported his/her concerns to the facility.

Interview with licensed nurse J on 1/22/14 at 8:56 a.m. revealed he/she was aware the resident wandered around the facility independently, had several falls in his/her room when staff were not present, wandered to his/her room after meals, and had a habit of reaching for items on the floor while he/she sat in his/her wheelchair. Staff J

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reported the resident attempted to pick up even small pieces of paper trash on the floor. Staff J reported the resident had a reacher bar to grasp items from the floor and direct care staff were to encourage and remind the resident to use it. Staff J revealed he/she was unaware the resident did not use the reacher. Staff J did state the resident really needed closer supervision such as one-to-one and or needed to be involved in more activities to keep busy and supervised.

During an interview on 1/22/14 at 8:40 a.m. Administrative nurse staff C reported residents who needed more supervision needed to be moved to a room closer to the nurse station, and nurse unit managers were expected to make all staff aware and encourage them to engage residents in more activities. Staff C reported he/she expected the unit charge nurse to enforce the interventions and monitor that staff followed them.

During an interview on 1/23/13 at 3:09 p.m. administrative staff A reported he/she expected activities staff to engage the resident in more activities.

Review of the undated facility accident prevention policy revealed all staff members will ensure each resident will receive adequate supervision and assistive devices to prevent accidents.

The facility failed to provide adequate supervision and failed to ensure the use of assistive devices to prevent an accident for resident #103.

- Observation of the Riffel house on 1/15/14 at 12:03 p.m. revealed an unlocked, unattended top

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drawer of a treatment cart held a 1/2 full Novolog insulin flex pen, a full Levimir insulin flex pen, a 30 ml (milliliter) tube of Lidocaine hydrochloride jelly (a topical numbing medication), and a 5 ml syringe of heparin (a blood thinning medication).

Interview with therapy staff GG on 1/15/14 at 12:04 p.m. confirmed the items found in the treatment cart should be locked up.

Interview on 1/15/14 at 12:18 p.m. with administrative nursing staff B revealed the Riffel neighborhood had been closed since sometime in October and the door to the neighborhood remained unlocked at all times. Staff B confirmed the medications were in an unsafe area and accessible to residents. Staff B reported he/she expected medications to be locked.

Review of the undated facility policy for Medication Storage revealed, "Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access."

The facility failed to prevent accidents by not ensuring the safe storage of medications in resident accessible areas.

- Observation of the Riffel house on 1/15/14 at 12:05 p.m. revealed the kitchen door off of the hinges and the kitchen unattended. Observation of two kitchen sinks revealed temperatures of 138.7 degrees F (Fahrenheit) and 134.2 degrees F.

Observation of maintenance staff FF on 1/15/14 at 12:20 p.m. revealed staff took the water temperature in the sinks of the unattended kitchen and confirmed the temperatures were too

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high and should be turned down. Staff FF reported his/her thermometer got up to 122 degrees F and was still rising when he/she took it out of the water. Staff FF reported the resident's were having cold water in their rooms when the dishwashers were running, so he/she had adjusted the water temperatures a few weeks prior and spot checked resident room water temperatures weekly.

Observation on 1/15/14 at 1:10 p.m. revealed a water temperature in the public bath at 130.6 degrees F in the Saghbene House.

Observation on 1/15/14 at 3:00 p.m. revealed maintenance staff FF took the temperature of the water in the public bathroom in the Saghbene House at 121.0 degrees F. Staff FF reported he/she had already turned down the temperatures after the high temperatures were brought to his/her attention by the surveyor earlier in the day.

Interview on 1/15/14 at 12:18 p.m. with administrative nursing staff B revealed the Riffel neighborhood had been closed since sometime in October and the door to the neighborhood remained unlocked at all times. Staff B confirmed the water temperatures were in unsafe areas accessible to residents.

According to Studies of Thermal Injury: II The Relative Importance of Time and Surface Temperatures in the Causation of Cutaneous Burns by A.R. Moritz and F.C. Henriques, Jr., a hot water temperature of 120 degrees F could cause 3rd degree burns (a burn through all 3 layers of the skin) in 5 minutes of exposure and a water temperature of 140 degrees F could cause

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3rd degree burns in 5 seconds of exposure.

Review of a facility policy dated 10/1/09 for Hot Water Testing revealed it lacked a range for safe water temperatures in resident areas.

The facility failed to prevent accidents by not ensuring the safe temperature of hot water in resident accessible areas.

- Observation of the Riffel house on 1/15/14 at 12:05 p.m. revealed the kitchen door off of the hinges and the kitchen unattended. Observation at that time also revealed an unlocked cabinet under the sink closest to the dishwasher contained a gallon bottle of UltraDry from EcoLab and approximately 30 oz of pot and pan ready-to-use detergent, both contained warnings to keep out of reach of children.

Observation on 1/15/14 at 1:25 p.m. revealed the environmental services office unlocked and unattended with the following chemical hazards with warnings to keep out of reach of children: a gallon of paint, ProChem Yellow Rx, Rane natural lemon disinfectant, Dupont grout sealer, WD 40, Ace ant, roach, and spider killer in an aerosol can, Goof Off, Members Mark laundry detergent family size, Tech stain remover gallon container, gallon of germicidal bleach, furniture polish, and fabric softener.

Observation on 1/15/14 from 1:25 p.m.-1:40 p.m. revealed multiple staff walked by open door with surveyor inside but out of direct line of sight and did not stop.

Interview with administrative nursing staff B on 1/15/14 at 1:40 p.m. confirmed multiple chemical

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F 323	Continued From page 47 hazards in the unlocked maintenance office and reported he/she expected chemicals to be in a locked area inaccessible to residents. Review of an undated facility policy for Accident Prevention revealed, "All hazardous materials will be stored in a manner inaccessible to residents." The facility failed to prevent accidents by not ensuring the safe storage of chemicals in resident accessible areas.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility census totaled 58 residents, and the facility reported all but 2 of those residents ate food prepared by one of the 3 kitchens in the facility. Based on observation, interview, and record review, the facility failed to prepare and serve food in a sanitary manner by the failure to properly restrain hair in 2 of 3 houses (Berlin-Sandy and Saghbene), and effectively sanitize dishes prior to serving the food to residents in 1 of 3 houses (Reddy). Issues in all 3 houses had the potential to affect all residents	F 371		

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who ate foods prepared by the facility.

Findings included:

- Observation on 1/15/14 at 11:45 a.m. in the Saghbene House revealed dietary staff BB and dietary staff Q wore hair nets as they prepared and served food from the kitchen. The staff members wore hair nets which did not cover the whole head and left hair uncovered and unrestrained. At 12:22 p.m. dietary staff BB continued to wear a hair net as he/she plated food for residents. The hair continued to stick out of the back of the hair net and had the potential to fall into the food.

Observation at 11:15 a.m. on 1/23/14 revealed dietary staff CC prepared food for the noon meal in the Berlin-Sandy house. He/she prepared pureed green beans and mashed potatoes. During that time, observation revealed staff CC had long hair in a hair net. Strands of hair and portions of braids stuck out of the hair net.

During an interview at 11:12 a.m. on 1/23/14, dietary staff Q reported he/she expected all hair to be covered by hair nets, and reported it sometimes hard to tell how well the hair net covered the hair.

Review of the facility's Food Preparation and Handling Policy, dated 4/21/13, revealed, "All food handlers are required to wear hair restraints (e.g., hair net and/or beard/moustache restraint) to ensure that hair is fully and completely covered, and hair/dandruff does not contaminate food or surfaces."

The facility failed to effectively restrain hair while

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preparing and serving food for residents.

- In Reddy house, interview with dietary staff AA on 1/22/14 at 10:35 a.m. revealed he/she looked at the front temperature display gauge on the dishwasher, and recorded the temperatures three times per day. He/she indicated the wash cycle should be between 150-160 degrees Fahrenheit (F) and 180-190 degrees F for the rinse cycle. At that time, staff AA ran a load through the dishwasher. Review of the temperatures of a digital thermometer which ran through with the load revealed the highest temperature during the load of 154.7 degrees F.

Interview with dietary staff Q on 1/22/14 at 1:15 p.m. revealed the dishwashers used high temperature sanitization and the wash cycle should be from 150-160 degrees F and the rinse cycle between 180-190 degrees F. Staff Q reported he/she asked the distributor because he/she thought it might be chemical sanitization, but the distributor confirmed the dishwasher sanitized by high heat. Staff Q reported he/she previously had issues with the dishwasher and had to have the distributor come out at times.

Interview on 1/23/14 at 11:22 a.m. with dietary staff Q revealed he/she had not had problems with the temperature of the water of that dishwasher, but had problems with the function of the machine leaking. Staff Q reported he/she spot checked randomly a couple of times a week with a meat probe thermometer the water at the bottom of the dishwasher after the washer had completed a cycle. Staff Q reported the water during the dishwasher cycle needed to be 180-190 degrees F for sanitization.

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Observation on 1/23/14 at 11:20 a.m. revealed dietary staff Q ran a digital thermometer and the facility's two meat probe thermometers through an entire dishwasher cycle. At the end of the cycle, the digital thermometer had a maximum temperature during the cycle of 149.3 degrees F. The temperatures on the meat thermometers continued to drop as staff Q removed them from the machine, but had temperatures of approximately 140 degrees F.

Interview with consultant Z from the distributor on 1/22/14 at 2:30 p.m. revealed he/she normally just went off of the gauges on the front of the dish machine when checking to ensure the machine maintained the proper temperatures, and did not check the internal temperatures unless there was a reason to question the accuracy of the gauges on the machine.

Review of the facility's undated Dietary Services Dishwashing policy revealed, "The dishes are rinsed for 70 seconds at a temperature of 180-200 degrees Fahrenheit...d. The operator should observe the temperature reading frequently. If the temperatures does not reach 140 degrees on the washing cycle and 180 degrees on the rinsing cycle, they should dispense with the operation and notify the Dietary Manager. The Dietary Manager should check to be sure the booster is turned up. If this is no the cause of the problem, the Administrator should be notified."

The facility failed to ensure the dishwashers maintained a rinse cycle temperature of at least 160 degrees F at dish level to properly sanitized the dishes prior to using them to serve food to residents.

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F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: - Review of resident #176's admission assessment dated 1/10/14 revealed the resident was alert and oriented to person, place, and time, understood others and could be understood by others. The resident had a regular diet with thin liquids and required moderate assistance with oral care. The resident had weakness and required extensive assistance of one staff for toilet use, transfers, and personal hygiene and the resident did not walk. Review of an AIMS (abnormal involuntary movement scale) assessment dated 1/10/14 revealed the resident wore dentures and had problems with his/her dentures. Review of the resident's admission care plan, initiated 1/10/14, revealed the resident was alert and oriented to person, place, and time, the	F 411		

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resident had upper dentures, and the lower were at home due to an ill fit.

Review of the resident's weights revealed on 1/10/14, the resident weighed 159.2 lbs (pounds) and on 1/19/14 weighed 146.8 lbs.

Review of a Nutritional Risk Review dated 1/10/14 revealed the assessment did not identify any oral function problems such as chewing or swallowing problems, ill fitting dentures, or refusing to wear dentures.

Review of nurses notes from 1/10/14-1/22/14 revealed no documentation of notification of social services about the resident's ill fitting lower dentures.

Observation on 1/21/14 at 8:01 a.m. revealed the resident sat at the dining table and had a cup of coffee and a small glass of water. The resident did not have bottom dentures in place. At 8:32 a.m. the resident was served a fried egg and a piece of white toast with butter and jelly. The resident ate 80% of the egg, all of the toast, and drank all of his/her fluids.

Observation on 1/22/14 at 11:55 a.m. revealed the resident sat at the dining table without his/her bottom teeth in place.

Interview with the resident on 1/15/14 at 4:04 p.m. revealed he/she had throat cancer and the radiation treatments caused some of his/her teeth to fall out. The resident reported he/she had top and bottom full dentures and had a set of bottom dentures he/she could not wear because they did not fit and caused him/her to have difficulty chewing some foods. The resident reported

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he/she did not know what the dentist could do because the radiation killed part of his/her bones.

Interview with the resident on 1/22/14 at 2:44 p.m. revealed his/her lower dentures did not fit and he/she left them at home. The resident reported the staff had not offered to set up any dental appointments for him/her, but he/she had interest in getting his/her dentures fixed so they fit.

Interview with direct care staff T on 1/21/13 at 3:51 p.m. revealed the resident had top and bottom dentures and staff soaked them for him/her at night. Staff T did not know of any problems with his/her dentures.

Interview with social services staff H on 1/22/14 at 3:53 p.m. revealed he/she was made aware of dental concerns from the nursing staff or from the MDS (minimum data set- a required assessment) after staff completed it. Staff H reported he/she expected staff to let him/her know if a resident had broken teeth, dentures that did not fit, issues with their gums, tongue, or mouth, or any loose teeth. Staff H reported if a resident had a concern, he/she visited with the resident and then called the resident's durable power of attorney to discuss the issue, and if a resident needed dental services, asked about the resident's dentist of choice, and notified transportation to make arrangements as needed. Staff H reported no one had let him/her know about the resident's loose bottom dentures and "it would have been nice" if the nursing had let him/her know so he/she could talk with the resident about it.

Interview with licensed nursing staff V on 1/21/14 at 4:14 p.m. revealed the resident had upper dentures and the lower dentures were at home

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F 411	Continued From page 54 due to not fitting right. Staff V reported the resident received a regular diet and had not complained of trouble eating. Review of the facility policy for Oral Health Care, dated 12/4/13, revealed "Each elder will receive an oral assessment by a licensed nurse on admission & [and] according to their MDS schedule... The assessment includes the condition of the oral cavity, teeth, and tooth supporting structures, the presence or absence of natural teeth or dentures and the ability to function with or without natural teeth or dentures... If at any time an elder, family or staff member believes that an elder is in need of a dental evaluation, nurse will contact the independent dental practitioner and make arrangements for the elder to be seen." The facility failed to provide dental services for a resident whose bottom dentures did not fit.	F 411		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by:	F 428		

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The facility had a census of 58 residents with 22 included in the sample. Based on interview and record review, the pharmacy failed to follow up on recommendations made during the monthly drug regimens and failed to recognize an inappropriate indication for use for a medication. This affected 2 of 22 residents. (#71, #92)

Findings included:

- Review of resident #92's physician order sheet dated 12/20/13 revealed the resident took Levothyroxine (thyroid medication) 300 mcg (micrograms) and Levothyroxine 50 mcg daily 1.5 tablets daily for a total dose of 375 mcg daily.

Review of the medical record revealed no TSH (thyroid stimulating hormone - a value indicating the effectiveness of the thyroid medication) were obtained since admission to the facility on 11/7/13.

During an interview on 1/23/14 at 11:18 a.m. licensed nurse staff J, reviewed the pharmacist notes dated 11/7/13 which revealed a request for TSH. Staff J also revealed a pharmacy review note dated 12/23/13 lacked a follow-up for the TSH lab. Staff J confirmed no labs were ordered for TSH tests in the resident's medical record since admission to the facility on 11/7/13.

During an interview on 1/27/14 at 4:10 p.m. consult staff HH revealed monitoring for thyroid medication should include a TSH level at least once a year. Staff HH reported recommendations from the pharmacy were sent via email to the facility, the facility then forwarded them to the physician or physician's staff for follow-up actions. Staff HH reported the pharmacy reviewed the

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residents' charts monthly.

During an interview on 1/23/14 at 11:25 a.m. physician staff X revealed he/she did not know the pharmacist had requested the TSH lab on 11/7/13, and did not know the TSH level had not been ordered. Staff X revealed he/she had just ordered the TSH lab for 1/27/14.

Review of the undated facility drug regimen review policy revealed the consultant pharmacist "will perform a drug regimen review on each elder at least monthly. All medications were reviewed for the appropriateness of medication, dose and current or potential impact as indicated by laboratory values. All concerns, issues or questions were clarified with the prescribing practitioner. The drug regimen review will identify medications used without adequate monitoring. When the attending physician fails to respond to a pharmacy drug regimen review within 5 working days, the physician will be contacted by the licensed nurse and/or the medical director."

The facility failed to follow-up on multiple recommendations made by the pharmacist.

- Review of resident #71's signed physician orders dated 12/20/13 revealed the following diagnoses: acute but ill-defined cerebrovascular disease (poor blood flow to areas of the brain), low blood pressure, and essential hypertension (elevated blood pressure). The resident admitted on 10/10/13.

Review of the admission MDS (minimum data set) dated 10/17/13 revealed a BIMS (brief interview for mental status) score of 12, indicating moderate cognitive impairment. The resident had

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a total mood severity score of 07, indicating mild depression. During the 7 day lookback period, the resident received an antidepressant medication 7 days, a hypnotic medication 5 days, and an antibiotic medication 3 days.

Review of the quarterly MDS dated 1/4/14 revealed a BIMS score of 12, indicating moderate cognitive impairment. The resident had a total mood severity score of 07, indicating mild depression. During the 7 day lookback period, the resident received antidepressant and antibiotic medications 7 days and a hypnotic 1 day.

Review of the Psychotropic Drug Use CAA (care area assessment) dated 10/22/13 revealed the following analysis of findings: "[Name] receives Citalopram Hydrobromide for depression, Ambien for sleep deprivation."

Review of the Cognitive Loss/Dementia CAA dated 10/22/13 revealed the following analysis of findings: "[Name] scored 12 of 15 on the BIMS, diagnosis of Ill defined cerebrovascular disease, ataxia [a neurological sign consisting of lack of voluntary coordination of muscle movements] as late effect of CVA [stroke-the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain], other late effects of CVA."

Review of the resident ' s care plan initiated 1/2/14, revealed interventions directed staff to discuss with physician and family the ongoing need for use of medications (added 12/13/13), educate the resident about risks, benefits and side effects of medications (added 12/13/13), and administer losartan potassium (Cozaar- a

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medication used to treat high blood pressure) as ordered (revised 1/3/14).

Review of the physician order summary dated 12/20/13 revealed an order for Cozaar 50 mg (milligrams) po (by mouth) give one tablet at bedtime with an indication for use listed as sleep. The order date listed was 10/10/13.

Review of a Drug Regimen Review form revealed the pharmacist conducted a review of the resident's medications on 5/2/13, 6/4/13, 7/2/13, 8/6/13, 9/17/13, 10/8/13, 11/7/13, and 1/9/14.

Review of a fax from the pharmacy on 1/22/14 revealed the pharmacist had reviewed the resident's medications on 12/13/13 and the pharmacist documented on the fax that it was not on the Drug Regimen Review form due to him/her inability to find the form in the expected place in the resident's chart at that time.

Interview with the resident on 1/21/14 at 10:35 a.m. confirmed the facility provided the resident's medications and he/she felt she got all of the medications he/she needed. The resident stated, "I sure do take a lot of pills, but I suppose they know what they are doing."

Interview with licensed nursing staff EE on 1/22/14 at 11:42 a.m. confirmed the indication for use for Cozaar was listed as sleep on the MAR (medication administration record) and the physician order summary and reported he/she had never seen it used for sleep. Staff EE reported he/she thought the medication was used to treat hypertension. Staff EE reported he/she thought the pharmacist reviewed the medications monthly, but he/she was not sure.

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F 428	Continued From page 59 Interview with administrative nursing staff B on 1/23/14 at 8:04 a.m. revealed Cozaar was not a medication typically used for sleep and he/she expected the pharmacist to catch the inappropriate indication for use. Staff B reported the pharmacist conducted monthly drug regimen reviews for each resident. Interview with consultant staff HH on 1/27/14 at 3:55 p.m. revealed during monthly drug regimen reviews, the pharmacy staff looked at many things such as indication for use, duration of use, lab work, and new physician orders. Staff HH reported Cozaar was a blood pressure medication and reported he/she know no reason for the medication to be used for sleep. Staff HH reported he/she expected pharmacy staff to catch an inappropriate indication for use if Cozaar was listed for sleep. Review of the undated facility policy for Drug Regimen Review revealed "The consultant pharmacist will perform a drug regimen review on each elder living in this facility at least monthly... All medications orders will be reviewed for:... Adequate and appropriate indications (diagnosis) for each ordered medication." The pharmacy failed to identify an inappropriate indication for use for the medication Cozaar.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431		

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F 431	Continued From page 60 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: The facility had a census of 58 residents. Based on observation and interview the facility failed to properly label resident insulin pens with the date opened, to ensure insulin pens would be discarded per the manufacturer's recommendations. This had the to potential to affect 4 of 20 residents who received insulin in	F 431		

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F 431	Continued From page 61 the Berlin house. Observation on 1/15/14 at 12:56 PM revealed 3 Lantus insulin pens and 4 Novolog insulin pens open at room temperature and available for use with no open date marked on the labels located in the Berlin resident house. Interview with licensed nurse L on 1/15/14 at 12:56 PM revealed the insulin pens were kept in the refrigerator until they were opened for resident use, then they were kept at room temperature. Staff L stated staff were expected to clearly mark the pens with the date opened which indicated to other staff the insulin pen would expire in 30 days from the date opened. Staff L verified the 7 insulin pens were opened for resident use and did not know when the insulin pens were opened. According to the manufacturer's directions for Levemir flex pen insulin once opened, keep at room temperature below 86 degrees for up to 42 days. According to the manufacturer's directions for Novolog flex pen insulin once opened, keep at room temperature below 86 degrees for 28 days. Review of the undated facility medication labels policy revealed, "at the time a multi-use vial is used for the first time, the nurse opening the vial will mark the date and time the vial was opened." The facility failed to ensure residents did not receive medication past the time of recommended use by failing to correctly label 7 in use insulin pens with an open or discard date.	F 431		